Michigan Association of Health Plans

MICHIGAN'S HEALTH CARE INSURANCE CHALLENGE

Rick Murdock
Executive Director
Michigan Association of Health Plans

WHO WE ARE

- The Michigan Association of Health Plans (MAHP) is an industry voice for 19 health care plans
- Members cover over 2.4 million Michigan residents
- Our mission: Advocate for health care that is
  - + High quality
  - + Affordable
  - + Accessible

WHO WE ARE

Aetna
Assurant
CareSource Michigan
Grand Valley Health Plan
Great Lakes Health Plan/United Health Care
Health Alliance Plan
Health Plan of Michigan, Inc.
HealthMarkets, Inc
HealthPlus of Michigan
McLaren Health Plan
Midwest Health Plan
Molina Healthcare of Michigan
OmniCare Health Plan
Paramount Care of Michigan
Physicians Health Plan-Mid-Michigan
Priority Health
ProCare Health Plan
Total Health Care, Inc.
Upper Peninsula Health Plan

WHO WE ARE

- National leaders in excellence
  - U.S. News & World Report/NCQA rankings show Michigan's health plans among the best in the country
    - 5 of the nation's top 50 commercial plans
    - 4 of the nation's top 25 Medicaid plans
    - 2 of the nation's top 25 Medicare plans

HEALTH MAINTENANCE ORGANIZATIONS

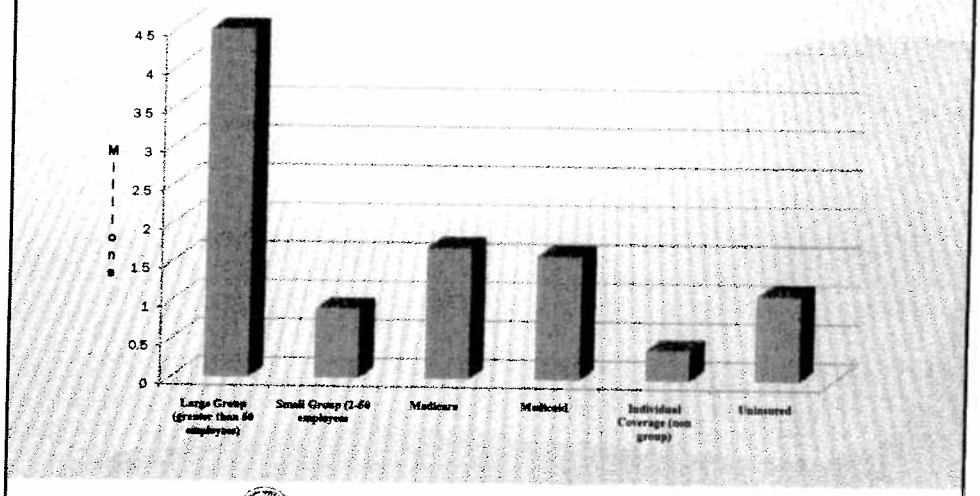
- Authorized under Chapter 35 of the Insurance Code
  - Specific regulatory responsibilities and obligations
  - Required to provide a comprehensive benefit plan as defined in statute
  - Required to join the financial and delivery aspects of health care through arrangements (contracts) with selected providers
- HMOs emphasize preventive care, services essential to good health
- HMOs are paid capitation, (per member per month) to deliver benefits described in contracts with purchasers and certificate of coverage
  - Are at 100% risk for coverage
  - Along with benefits negotiated with the purchaser, HMO must also provide mandated HMO benefits contained in Chapter 35
- HMOs accredited by the National Committee on Quality Assurance (NCQA) via independent process

HEALTH MAINTENANCE ORGANIZATIONS

- Annual audited data is collected and forwarded to NCQA for performance purposes and annual rankings (HEDIS data set)
- Evidence-based practices key to HMO philosophy
  - Demonstrate effectiveness of programs, practices and products
  - Most HMOs participate with the Michigan Quality Improvement Committee (MQIC) to develop common sets of guidelines for providers
- The State of Michigan contracts with HMOs for Medicaid services (over 1 million Medicaid beneficiaries), and as option for State active employees and retirees
- Role of HMOs in the Market Place:
  - Large market (>50 employees)
  - Small market (2-50 employees)
  - Individual Market

ABOUT 1 MILLION UNINSURED IN MICHIGAN

Michigan Insurance Coverage Estimates by Category: 2008



COMMERCIAL HEALTH PLANS

- Basic Regulation under parts 34 and 36 of the Insurance Code
  - Regulated as disability or life insurance companies who provide health benefits.
- Commercial health plans contract with preferred networks of providers and use discounted rates for in-network delivery of services.
  - Benefit plans are based on purchaser contracts and are flexible– not mandated as with HMO benefits.
- Commercial Plans are becoming accredited by NCQA and are using managed care techniques and programs to help in managing care for their subscribers.

COMMERCIAL HEALTH PLANS

- Role of Commercial Plans in Market Place:
  - Large Market (>50 employees)
  - Small Market (2-50 employees)
  - Individual Market

Q: WHAT IS MICHIGAN'S MOST PRESSING HEALTH INSURANCE ISSUE?

A: Access to affordable choices

We need to ensure that all people have access to reasonably robust health care plans at a cost they can afford

WHAT WE HAVE LEARNED IN MICHIGAN

- Not all small businesses are same
- Competition works to hold down rates
- Choices are important
  - + Our members offer a variety of options
  - + Do need to level playing field so all insurers can offer more options

LEVEL PLAYING FIELD: BENEFITS FLEXIBILITY

HMO ACT	Insurance Code	P.A. 350
HMOs do not enjoy benefit flexibility and must provide a wide array of mandatory benefit offerings including "Basic Health Services". MCL 500.3501. HMOs must also provide coverage required under Chapters 34 and 36 of the Insurance Code. MCL 500.3503. HMO contracts must also provide hospital and physician services "*when medically indicated*"; resulting in more mandatory benefits than insurance companies. MCL 500.3501(e).	Insurers are not required to sell standardized policies, but may design different policies as needed. Must still cover mandated benefits. MCL 500.3406a-3406e, 500.3406p-3406q, 500.3609a-3610, 500.3613-3616a. Insurers are <u>not</u> subject to HMO Act's "medically indicated" services or "Basic Health Services" requirements.	BCBSM may limit the benefits it will furnish and may divide those benefits it elects to furnish into classes or kinds. MCL 550.1401(2). Must still cover mandated benefits. MCL 550.1415, 550.1416, 550.1416a, 550.1416b.

LEVEL PLAYING FIELD:REQUIRED OFFERINGS

HMO ACT	Insurance Code	P.A. 350
Under current law, an HMO can only offer a "Traditional" HMO product. Upon prior approval, it may also offer a PPO or point of service product. MCL 500.3533.	Required to offer for purchase a traditional indemnity product when it offers a prudent purchaser arrangement (e.g. PPO). *See* MCL 500.3405(2)-(3) for individual offerings and MCL 500.3631(5)-(6) for offerings to groups.	Required to offer for purchase the traditional Blue Cross product when it offers a prudent purchaser arrangement (e.g. PPO). MCL 550.1502a(7)-(8) for individual offerings and MCL 550.1502a(2)-(6) for offerings to groups.

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LEVEL PLAYING FIELD: COMMERCIAL RATE FILINGS

HMO ACT	Insurance Code	P.A. 350
General Rule: Filed and Approve - New rates and changes in rates or methodology. MCL 500.3521(1). Exception: File and Use - Rates or rate changes developed through collective bargaining. MCL 500.3525(2). Special Rules: All rates are approved for only one year.	General Rule: No filing requirement. Exception: File and Use - Individual rates. MCL 500.3474.	General Rule: Filed and Approve - Individual rates, group rating systems (Area or Experience), and changes in rates due to a new certificate. MCL 550.1608 (1)-(2), MCL 550.1607(1). Special Rules: OFIR must approve a proposed rate filed in connection with a new or revised certificate if the rate is equitable, adequate and not excessive. MCL 550.1607(4). OFIR may allow implementation of rates before the certificate is filed. MCL 550.1607(5)-(7). Area Rate and Experience Rate System methodologies (groups) must be filed once every 3 years. MCL 550.1608(2).

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LEVEL PLAYING FIELD: COMMERCIAL CONTRACT AND POLICY FORM FILINGS

HMO ACT	Insurance Code	P.A. 350
General Rule: Filed and Approve - Individual and Group Contracts. MCL 500.3523(1). Exception: File and Use - Contracts resulting from collective bargaining. MCL 500.3525(2).	Exception: OFIR has exempted policy form filings altogether under Bulletin 97-03 pursuant to 500.2236(8)(d).	General Rule: Filed and Approve - Individual and group certificates (new or revised). MCL 550.1607(1). Exception: File and Use - Certificates resulting from collective bargaining. MCL 550.1607(2). Special Rules: Certificates are "deemed approved" 30 days after filing, but may be subsequently disapproved. MCL 550.1607(1). A certificate shall be approved if it is not "unjust, unfair, inequitable, misleading, deceptive or encourages misrepresentation." MCL 550.1607(4)(b). OFIR must provide notice of disapproval or approval and may approve "with modifications." MCL 550.1607(5),(6). OFIR may permit a certificate to be used before being filed. MCL 550.1607(7).

LEVEL PLAYING FIELD: USE OF EXPERIENCE RATING

HMO ACT	Insurance Code	P.A. 350
HMO Act does not expressly address experience rating.	Insurers may not experience rate individuals in connection with individual conversion policies. MCL 500.3612(8). Groups may be experience rated since the above prohibition deals with individual rating only.	Groups of 100 or more are currently experience rated under the Experience Rate System filed under MCL 550.1608(2).

LEVEL PLAYING FIELD: SELF-FUNDED/ASO ARRANGEMENTS

HMO ACT	Insurance Code	P.A. 350
An HMO may not enter into an ASO arrangement, but its subsidiaries/affiliates may do so. *See* MCL 500.3503(2).	May enter into ASO arrangements, but may have obligation to provide or arrange stop loss coverage depending on size of employer group. MCL 500.5208 and 500.5208a.	BCBSM may enter into ASO arrangements, but may be required to provide or arrange stop loss coverage depending on size of employer group. MCL 550.1211.

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LEVEL PLAYING FIELD: FINANCIAL STANDARDS

HMO ACT	Insurance Code	P.A. 350
Net Worth: If 90% or more of the benefit payout is to network providers, the minimum net worth of an HMO is the greater of: (a) $1.5 million, (b) 4% of premium revenues, or (c) three months' uncovered expenditures. MCL 500.3551(3)(a). If less than 90% of the benefit payout is to out-of-network providers, the minimum net worth of an HMO is the greater of: (a) $3.0 million, (b) 10% of premium revenues, or (c) three months' uncovered expenditures. MCL 500.3551(3)(b). Risk Based Capital: Requirements set by OFIR. MCL 500.3551(4). *See* OFIR Bulletin 98-02 issued June 15, 1998 ("Bulletin 98-02").	Net Worth: Must maintain capital and surplus not less than $7.5 million. MCL 500.410. Risk Based Capital: Requirements set by OFIS (same as HMO). MCL 500.403. *See* OFIR Bulletin 98-02.	Risk Based Capital: Requirements set by OFIS. MCL 550.1204a(1). BCBSM must have at least 200% RBC. MCL 500.1204a(5). If RBC exceeds 1000% for 2 consecutive calendar years, BCBSM must submit a corrective plan with OFIR to return the excess to its customers. MCL 500.1204a(5).

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LEVEL PLAYING FIELD: GEOGRAPHIC LIMITS ON PRODUCT/SERVICE OFFERINGS

HMO ACT	Insurance Code	P.A. 350
HMOs, which operate under a certificate of authority, may only provide services and market contracts within the specified "service area" designated in the certificate. MCL 500.3501(l).	Unlike HMOs, the Insurance Code does not restrict commercial carriers from offering products or services within a particular geographic area. An insurer licensed in Michigan is authorized to write health insurance throughout the state. However, if the insurer offers a PPO product, it must "assure reasonable levels of access" within the "geographic area served by the organization." MCL 550.53.	BCBSM is to offer coverage throughout the state of Michigan. However, each subscriber's certificate must describe the "service area." MCL 550.1402a. If BCBSM offers a PPO product, it must "assure reasonable levels of access" within the "geographic area served by the organization." MCL 550.53.

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LEVEL PLAYING FIELD: PROMULGATION OF RULES BY COMMISSIONER

HMO ACT	Insurance Code	P.A. 350
As a general matter, the Commissioner has authority but is not mandated to promulgate rules.	As a general matter, the Commissioner has authority but is not mandated to promulgate rules.	As a general matter, the Commissioner has authority but is not mandated to promulgate rules.

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LEVEL PLAYING FIELD: USE OF HEALTH STATUS IN PREMIUM RATING

HMO ACT	Insurance Code	P.A. 350
Health status is not a permitted rating factor under the HMO Act (MCL 500.3519), nor under Small Group Reform (MCL 500.3705).	No express prohibition and thus may be used as a rating factor. Small Group Reform expressly permits health status as a rating factor. MCL 500.3705.	P.A. 350 does not expressly prohibit health status as a rating factor, however, its use may be viewed as inconsistent with concepts of "equitable" and "uniform" rates under MCL 550.1609 and 550.1611. Health status is not a permitted factor under Small Group Reform. MCL 500.3705. Groups under 100 are currently "community" rated under the Area Rate System filed under MCL 550.1608(2).

LEVEL PLAYING FIELD: STANDARDS FOR RATES

HMO ACT	Insurance Code	P.A. 350
Fair, sound and reasonable in relation to services provided. MCL 500.3519(1).	As respects certain coverages, supported by actuarial certification that benefits provided are reasonable in relation to the premium charged (must include anticipated loss ratio). MCAR 500.803.	Equitable, adequate (i.e. self sustaining), and not excessive. MCL 550.1608; See also MCL 550.1609 regarding what constitutes an excessive, adequate and/or equitable rate. Legislative policy is to have uniform rates. MCL 500.1611.

LEVEL PLAYING FIELD: SMALL GROUP REFORM PERMITTED RATING FACTORS AND RATE VARIANCES

HMO ACT	Insurance Code	P.A. 350
Permitted Rating Factors: Industry, Age and Group Size. MCL 500.3705. Rate Variance: Variance permitted up to 35% of the index rate. MCL 500.3705(2)(ii).	Permitted Rating Factors: Industry, Age, Group Size and Health Status. MCL 500.3705. Rate Variance: Variance permitted up to 45% of the index rate. MCL 500.3705(2)(c)(iii).	Permitted Rating Factors: Industry and Age. MCL 500.3705. Rate Variance: Variance permitted up to 35% of the index rate. MCL 500.3705(2)(ii).

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LEVEL PLAYING FIELD: PARTICIPATION AND PROVIDER CONTRACTS

HMO ACT	Insurance Code	P.A. 350
Must arrange services through a provider network subject to access standards. MCL 500.3513(2)(a). May offer a prudent purchaser product (PPO or Point of Service) where enrollees have an out-of-network benefit. MCL 500.3533. Provider contract forms must be filed with OFIR and meet certain requirements. MCL 500.3521; 500.3531.	May offer a prudent purchaser product (PPO or Point of Service) where insureds have a financial incentive to obtain services in-network. MCL 500.3405; 500.3631.	BCBSM must enter into reimbursement arrangements with an "appropriate number" of providers to assure the availability of covered health care services to each subscriber. MCL 550.1504(1). The form of provider contract and the reimbursement arrangement are referred to as "provider class plans." MCL 550.1107. BCBSM is generally prohibited from making payment to non-participating providers. MCL 550.1401(7). BCBSM must make annual filings with respect to class plans relative to statutory goals of cost, quality and access. MCL 550.1504. BCBSM may offer prudent purchaser products (PPO or Point of Service) where the enrollees have a financial incentive to obtain services in-network. MCL 550.1502a. Provider class plan obligations do not apply to PPO or POS products. MCL 550.1502a(10). With respect to professional providers such as physicians, participating contracts may cover all BCBSM members or be a separate contract on per-claim basis. MCL 550.1502(1).

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LEVEL PLAYING FIELD: PRE-EXISTING CONDITION EXCLUSIONS

HMO ACT	Insurance Code	P.A. 350
A) Individual: Permitted, so long as the exclusion or limitation relates to a condition: a) for which medical advice, diagnosis, care or treatment was recommended or received within 6 months before enrollment; and b) the exclusion or limitation does not extend more than *6 months* after the effective date of the HMO contract. MCL 500.3539(1). B) Group: Prohibited. MCL 500.3539(2).	Permitted, so long as the exclusion or limitation relates to a condition: a) for which medical advice, diagnosis, care or treatment was recommended or received within 6 months (individual and group) before enrollment; and b) the exclusion or limitation does not extend more than - 12 months (individual) - 6 months (small group) - 12 months (large group) after the policy takes effect. MCL 500.3406f(a), (b) and (c). Under HIPAA, the exclusion period (group) is required to be reduced by the number of days of "creditable coverage". 45 CFR 146.111.	Individual: Permitted, so long as the exclusion or limitation relates to a condition: a) for which medical advice, diagnosis, care or treatment was recommended or received within 6 months before enrollment; and b) the exclusion or limitation does not extend more than *6 months* after the effective date of the certificate. MCL 550.1402b(1). However, BCBSM may not exclude or limit coverage for a pre-existing condition *or impose a waiting period* if a person is deemed to be *HIPAA eligible*. MCL 550.1402b(3), 45 CFR 148.128(a)(ii). Group: Prohibited. MCL 550.1402b(2).

LEVEL PLAYING FIELD: GUARANTEED ISSUE

HMO ACT	Insurance Code	P.A. 350
Individual: HMOs must generally offer coverage during an annual 30-day open enrollment period and may not deny coverage based on health status. MCL 500.3537. HMOs are not subject to HIPAA's guaranteed issue requirements because BCBSM constitutes an "acceptable alternative mechanism" under 45 CFR 148.128. Small Group: Must offer all health plans they market to *any* small employer in the state to *all* small employers in the state, and issue a policy to *any* small employer that applies for a plan, agrees to the premium and other reasonable conditions. MCL 500.3707(1). A similar obligation exists under HIPAA. 45 CFR 146.150. HMOs may deny coverage to a small employer group if the group fails to meet the law's minimum participation requirements. MCL 500.3709. Large Group: Not required to make coverage available in the large group market.	Individual: No requirement to make coverage available in the individual market, so may refuse coverage based on health status. Insurers are not subject to HIPAA's guaranteed issue requirements because BCBSM constitutes an "acceptable alternative mechanism" under 45 CFR 148.128. Small Group: Must offer all health plans they market to *any* small employer in the state to *all* small employers in the state and issue a policy to *any* small employer that applies for a plan, agrees to the premium and other reasonable conditions. MCL 500.3707(1). Similar requirement under HIPAA. 45 CFR 146.150. May deny coverage to a small employer group if the group fails to meet the law's minimum participation requirements. MCL 500.3709. Large Group: Not required to make coverage available in the large group market.	BCBSM must generally offer coverage to any resident in Michigan. MCL 550.1401(3). While HIPAA contains some additional rules that apply to individual coverage, they do not apply if the state has designated an "alternative mechanism". Michigan has designated BCBSM as the acceptable alternative mechanism. 45 CFR 148.128. Must offer all health plans they market to *any* small employer in the state to *all* small employers in the state and issue a policy to *any* small employer that applies for a plan, agrees to the premium and other reasonable conditions . MCL 500.3707(1). A similar obligation exists under HIPAA. 45 CFR 146.150. May deny coverage to a small employer group if the group fails to meet the law's minimum participation requirements. MCL 500.3709. May deny coverage to non-reform groups under very limited situations where strong evidence of adverse selection. MCL 550.1401.

LEVEL PLAYING FIELD: REVIEW OF BENEFIT DENIALS

HMO ACT	Insurance Code	P.A. 350
Must maintain an informal grievance procedure for enrollees to dispute adverse benefit decisions; Also subject to Patient's Right to Independent Review Act ("PRIRA"). MCL 500.2213; MCL 550.1901, et. seq.	Must maintain an informal grievance procedure for enrollees to dispute adverse benefit decisions; Also subject to PRIRA. MCL 500.2213; MCL 550.1901, et. seq.	Must maintain an informal grievance procedure for enrollees to dispute adverse benefit decisions; Also subject to PRIRA. MCL 550.1404; MCL 550.1901, et. seq.

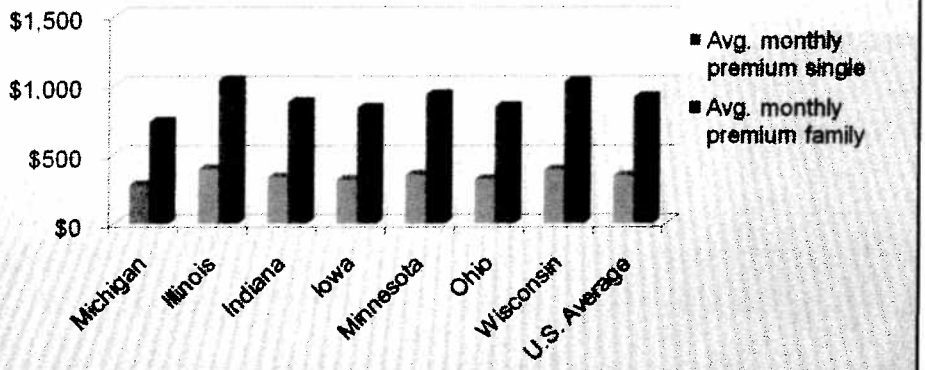
MICHIGAN OVERVIEW

All small group market health insurance:
Michigan premium low compared to Midwest average
5th lowest in U.S.

2008 data	Avg. monthly premium single	Avg. monthly premium family
Michigan	**$280**	**$738**
Illinois	$393	$1,035
Indiana	$333	$878
Iowa	$317	$835
Minnesota	$353	$932
Ohio	$320	$845
Wisconsin	$388	$1,024
U.S. Average	**$346**	**$913**

Source: AHIP Small Group Health Insurance in 2008 issued March 2009

MICHIGAN OVERVIEW: SMALL GROUP



Michigan lowest in Midwest, 5th lowest in U.S.

Source: AHIP Small Group Health Insurance in 2008 issued March 2009

MICHIGAN OVERVIEW

Very small group market health insurance (10 or fewer employees):
Michigan premium low compared to Midwest average
3rd lowest in U.S.

2008 data	Avg. monthly premium single	Avg. monthly premium family
Michigan	**$282**	**$745**
Illinois	$424	$1,117
Indiana	$366	$966
Iowa	$341	$899
Minnesota	$361	$952
Ohio	$347	$914
Wisconsin	$408	$1,075
U.S. Average	**$378**	**$996**

Source: AHIP Small Group Health Insurance in 2008 issued March 2009

MICHIGAN OVERVIEW

Individual market health insurance:
Michigan premium low compared to Midwest average

2006 data	Individual Market Single (annual)	Individual Market Family (annual)
Michigan	**$1,926**	**$3,968**
Illinois	$2,591	$4,991
Indiana	$2,330	$4,803
Iowa	$1,965	$3,653
Minnesota	$2,121	$4,141
Ohio	$2,304	$4,541
Wisconsin	$2,373	$4,462
U.S. Average	**$2,268**	**$4,424**

Source: AHIP Health Insurance: Overview and Economic Impact in the States December, 2006

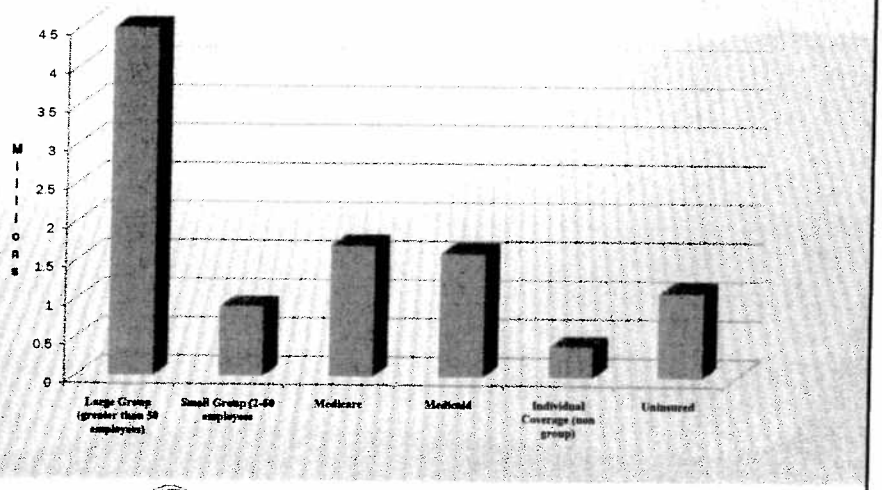
Q: WHAT IS MICHIGAN'S MOST PRESSING HEALTH INSURANCE ISSUE?

A: Access to affordable choices

We need to ensure that all people have access to reasonably robust health care plans at a cost they can afford

ABOUT 1 MILLION UNINSURED IN MICHIGAN

Michigan Insurance Coverage Estimates by Category: 2008



CRITICAL FOR MICHIGAN

- About 1 million uninsured
- Drives up health care cost for all
- Still get health care
  - Often at expensive emergency rooms
  - Uncompensated care = Cost shifting
  - Average family paying $800/year due to uncompensated care
- Getting more people into managed care can mean lower costs for all

DESIRED CHARACTERISTICS OF ACCESS TO CARE INITIATIVE

- Create a level playing field for all insurers
- Consumer-centric
- Serving greater public good not one interest
- Take pressure off of other insurers (cross-subsidy, uncompensated care)

DESIRED CHARACTERISTICS OF ACCESS TO CARE INITIATIVE

- All interest groups have a stake in its implementation (Pay/Play)
- Increases competition across the board
- Advances competition on quality and performance
- Must provide certainty of coverage, costs, and responsibility.

KEY CONCEPTS

- Standard benefits package
- Target premium cost: about $200/month
- All carriers must offer
- Low income subsidized in some fashion
- Community rating with perhaps age factor
- Consistent treatment of pre-existing conditions by all carriers
  - Goal is to limit gaming of system
  - But still ensure in need can get care

KEY CONCEPTS

- Consideration of subsidies funded by combination of government & private sector
- Reinsurance options/pools
- Potential short-term options (less than 12 months) to cover the newly uninsured

PERSONAL ACCOUNTABILITY, WELLNESS

- Positive use of incentives and copay
- Encourage utilization of preventive services
- Discourage utilization of high cost services.

So: No copay for diabetes drugs

Major copay for going to emergency room if not admitted

MAXIMIZE USE OF MEDICAID/MICHILD (PRESERVING SAFETY NET)

- Established programs
- History of working well
- Need to ensure all people who are eligible are in these programs
- Let's federal government share costs

QUALITY

- Support public and private sector payment innovations to link payment with quality performance
- Address overuse, underuse, and misuse of health care resources
- Improve management of chronic conditions and deployment of appropriate technology (e.g., electronic health record)

EFFICIENCY

Boost use of health care technology

Administrative and clinical management

Take advantage of support available in the Stimulus Package

Let's "jumpstart" the availability of technology.

OTHER REFORMS

- Recognize some regulatory reform needed
  - + Make it easier for carriers to bring products to market
  - + Accelerated rate approval process for all carriers
    - × This prevents rate shocks
    - × Increases competition
  - + Preserving appropriate regulatory oversight

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MICHIGAN'S HEALTH CARE INSURANCE CHALLENGE

Michigan Association of Health Plans

Glossary of Key Terms

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GLOSSARY OF KEY TERMS

Adverse Selection	People with a higher than average risk of needing health care are more likely than healthier people to seek health insurance. Health insurers strive to maintain risk pools of people whose health, on average, is the same as that of the general population. Adverse selection results when the less healthy people disproportionately enroll in a risk pool.
Consumer-Directed Health Plans	Consumer-directed health plans seek to increase consumer awareness about health care costs and provide incentives for consumers to consider costs when making health care decisions. These health plans usually have a high deductible accompanied by a consumer-controlled savings account for health care services. There are two types of savings accounts: Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs).
Co-Payment	A fixed dollar amount paid by an individual at the time of receiving a covered service from a participating provider. Individuals with private and public insurance may be required to pay.
Federal Medical Assistance Percentage (FMAP)	The statutory term for the federal Medicaid matching rate—i.e., the share of the costs of Medicaid services or administration that the federal government bears. In the case of covered services, FMAP varies from 50 to 76 percent depending upon a state's per capita income; on average, across all states, the federal government pays at least 60 percent of the costs of Medicaid.
Federal Poverty Level (FPL)	The federal government's working definition of poverty that is used as the reference point for the income standard for Medicaid eligibility for certain categories of beneficiaries. Adjusted annually for inflation and published by the Department of Health and Human Services in the form of Poverty Guidelines, the FPL in calendar year 2007 was $20,650 for a family of four.
Group health insurance	Health insurance that is offered to a group of people, such as employees of a company. The majority of Americans have group health insurance through an employer.
Health Savings Account (HSA)	A savings account that is often available to people with a high deductible health plan. Contributions to the account are not taxable and the funds can be used for qualified health care expenses.
Individual Insurance Market	The market for individuals who choose to purchase private medical insurance on their own.
Mandatory benefits	All states have laws that require state-licensed health insuring organizations selling health coverage to offer or include coverage for certain benefits or services, including items such as mental health services, substance abuse treatment, and breast reconstruction following a mastectomy. The number and type of these mandates varies across states.
Medicaid Waivers	Various statutory authorities under which the Secretary of the U.S. Department of Health and Human Services may, upon the request of a state, allow the state to receive federal Medicaid matching funds for its expenditures for certain categories of individuals for which federal matching funds are not otherwise available.
Medical Underwriting	Underwriting is the process of determining whether or not to accept an applicant for health care coverage and looking at their medical history in order to predict future health risks. This process determines what the terms of coverage will be, including the premium cost.
National Health System	A publicly funded health care system in which all individuals have health insurance. Examples include the health systems in England and Germany.

Pay For Performance	A health care model in which providers are rewarded for providing high quality health care services.
Purchasing Pools	Health insurers pool the health care risks of a group of people in order to make the individual costs predictable and manageable. For health coverage arrangements to perform well, the risk pooling should balance low and high risk individuals such that expected costs for the pool are reasonably predictable for the insurer and relatively stable overtime.
Pre-existing Condition Exclusions	An illness or medical condition for which a person received a diagnosis or treatment within a specified period of time prior to becoming insured under a policy. Health insurers can exclude benefits for a defined period of time for the treatment of medical conditions that they determine to have existed within a specific period prior to the beginning of coverage.
Refundable Tax Credit	A tax credit that can reduce the taxes an individual owes to below zero dollars, which results in a net payment to the individual. An example includes the Earned Income Tax Credit (EITC).
Section 125/ Cafeteria Plan	A section 125 plan allows employees to receive specified benefits on a pre-tax basis. Qualified benefits include health benefits and health savings accounts.
Self-insured Plan	A plan where the employer assumes direct financial responsibility for the costs of enrollees' medical claims. Employers sponsoring self-insured plans typically contract with a third-party administrator or insurer to provide administrative services for the self-insured plan.
Single Payer System	A health care system in which a single entity pays for health care services. This single entity collects health care fees and pays for all health care costs, but is not involved in the delivery of health care.
Small Group Market	Firms with 2-50 employees can purchase health insurance for their employees through this market, which is regulated by the states.
Socialized Medicine	A health care system in which the government operates and administers health care facilities and employs health care professionals. Examples include the Veterans Health Administration.
State Children's Health Insurance Program (SCHIP)	Enacted in 1997, SCHIP is a federal-state matching program of health care coverage for uninsured low-income children. SCHIP is a block grant to the states. States have the option of administering SCHIP through their Medicaid programs or through a separate program (or a combination of both).
Tax Credit	A tax credit is an amount that a person can subtract from the amount of income tax that they owe. If a tax credit is refundable, the taxpayer can receive a payment from the government to the extent that the amount of the credit is greater than the amount of tax that the individual would otherwise owe.
Tax Deduction	A deduction is an amount that a person can subtract from their adjusted gross income when calculating the amount of tax that they owe. Generally, families that itemize their deductions can deduct the portion of their medical expenses, including health insurance premiums that exceed 7.5% of their adjusted gross income.
Uncompensated Care	A measure of the cost of health care services that are provided but not paid for by the patient or by insurance. Health care providers incur some of this cost along with the federal government.
Underinsured	People who have health insurance but face significant health care costs or limits on benefits, which may affect its usefulness in accessing or paying for health care services.

Michigan Association of Health Plans

HMO Act - Crosswalk

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HMO ACT CROSSWALK

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Updated 3/17/09

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Benefits Flexibility

HMO ACT	Insurance Code	P.A. 350
HMOs do not enjoy benefit flexibility and must provide a wide array of mandatory benefit offerings including "Basic Health Services". MCL 500.3501. HMOs must also provide coverage required under Chapters 34 and 36 of the Insurance Code. MCL 500.3503. HMO contracts must also provide hospital and physician services "***when medically indicated***"; resulting in more mandatory benefits than insurance companies. MCL 500.3501(e).	Insurers are not required to sell standardized policies, but may design different policies as needed. Must still cover mandated benefits. MCL 500.3406a-3406e, 500.3406p-3406q, 500.3609a-3610, 500.3613-3616a. Insurers are <u>not</u> subject to HMO Act's "medically indicated" services or "Basic Health Services" requirements.	BCBSM may limit the benefits it will furnish and may divide those benefits it elects to furnish into classes or kinds. MCL 550.1401(2). Must still cover mandated benefits. MCL 550.1415, 550.1416, 550.1416a, 550.1416b.

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HMO ACT CROSSWALK

I. Required Benefit Plan Offerings

HMO ACT	Insurance Code	P.A. 350
Under current law, an HMO can only offer a "Traditional" HMO product. Upon prior approval, it may also offer a PPO or point of service product. MCL 500.3533.	Required to offer for purchase a traditional indemnity product when it offers a prudent purchaser arrangement (e.g. PPO). *See* MCL 500.3405(2)-(3) for individual offerings and MCL 500.3631(5)-(6) for offerings to groups.	Required to offer for purchase the traditional Blue Cross product when it offers a prudent purchaser arrangement (e.g. PPO). MCL 550.1502a(7)-(8) for individual offerings and MCL 550.1502a(2)-(6) for offerings to groups.

HMO ACT CROSSWALK

II. Commercial Rate Filings

HMO ACT	Insurance Code	P.A. 350
General Rule: **Filed and Approve** - New rates and changes in rates or methodology. MCL 500.3521(1). Exception: **File and Use** - Rates or rate changes developed through collective bargaining. MCL 500.3525(2). Special Rules: All rates are approved for only one year.	General Rule: No filing requirement. Exception: **File and Use** - Individual rates. MCL 500.3474.	General Rule: **Filed and Approve** - Individual rates, group rating systems (Area or Experience), and changes in rates due to a new certificate. MCL 550.1608 (1)-(2), MCL 550.1607(1). Special Rules: OFIR must approve a proposed rate filed in connection with a new or revised certificate if the rate is equitable, adequate and not excessive. MCL 550.1607(4). OFIR may allow implementation of rates before the certificate is filed. MCL 550.1607(5)-(7). Area Rate and Experience Rate System methodologies (groups) must be filed once every 3 years. MCL 550.1608(2).

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III. Commercial Contract and Policy Form Filings

HMO ACT	Insurance Code	P.A. 350
General Rule: **Filed and Approve** - Individual and Group Contracts. MCL 500.3523(1). Exception: **File and Use** - Contracts resulting from collective bargaining. MCL 500.3525(2).	Exception: OFIR has exempted policy form filings altogether under Bulletin 97-03 pursuant to 500.2236(8)(d).	General Rule: **Filed and Approve** - Individual and group certificates (new or revised). MCL 550.1607(1). Exception: **File and Use** - Certificates resulting from collective bargaining. MCL 550.1607(2). Special Rules: Certificates are "deemed approved" 30 days after filing, but may be subsequently disapproved. MCL 550.1607(1). A certificate shall be approved if it is not "unjust, unfair, inequitable, misleading, deceptive or encourages misrepresentation." MCL 550.1607(4)(b). OFIR must provide notice of disapproval or approval and may approve "with modifications." MCL 550.1607(5),(6). OFIR may permit a certificate to be used before being filed. MCL 550.1607(7).

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IV. Use of Experience Rating

HMO ACT	Insurance Code	P.A. 350
HMO Act does not expressly address experience rating.	Insurers may not experience rate individuals in connection with individual conversion policies. MCL 500.3612(8). Groups may be experience rated since the above prohibition deals with individual rating only.	Groups of 100 or more are currently experience rated under the Experience Rate System filed under MCL 550.1608(2).

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V. Self-Funded/ASO Arrangements

HMO ACT	Insurance Code	P.A. 350
An HMO may not enter into an ASO arrangement, but its subsidiaries/affiliates may do so. *See* MCL 500.3503(2).	May enter into ASO arrangements, but may have obligation to provide or arrange stop loss coverage depending on size of employer group. MCL 500.5208 and 500.5208a.	BCBSM may enter into ASO arrangements, but may be required to provide or arrange stop loss coverage depending on size of employer group. MCL 550.1211.

HMO ACT CROSSWALK

VI. Financial Standards

HMO ACT	Insurance Code	P.A. 350
Net Worth: If 90% or more of the benefit payout is to network providers, the minimum net worth of an HMO is the greater of: (a) $1.5 million, (b) 4% of premium revenues, or (c) three months' uncovered expenditures. MCL 500.3551(3)(a). If less than 90% of the benefit payout is to out-of-network providers, the minimum net worth of an HMO is the greater of: (a) $3.0 million, (b) 10% of premium revenues, or (c) three months' uncovered expenditures. MCL 500.3551(3)(b). **Risk Based Capital:** Requirements set by OFIR. MCL 500.3551(4). *See* OFIR Bulletin 98-02 issued June 15, 1998 ("Bulletin 98-02").	**Net Worth:** Must maintain capital and surplus not less than $7.5 million. MCL 500.410. **Risk Based Capital:** Requirements set by OFIR (same as HMO). MCL 500.403. *See* OFIR Bulletin 98-02.	**Risk Based Capital:** Requirements set by OFIR. MCL 550.1204a(1). BCBSM must have at least 200% RBC. MCL 500.1204a(5). If RBC exceeds 1000% for 2 consecutive calendar years, BCBSM must submit a corrective plan with OFIR to return the excess to its customers. MCL 500.1204a(5).

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VII. Geographical Limits on Product/Service Offerings

HMO ACT	Insurance Code	P.A. 350
HMOs, which operate under a certificate of authority, may only provide services and market contracts within the specified "service area" designated in the certificate. MCL 500.3501(1).	Unlike HMOs, the Insurance Code does not restrict commercial carriers from offering products or services within a particular geographic area. An insurer licensed in Michigan is authorized to write health insurance throughout the state. However, if the insurer offers a PPO product, it must "assure reasonable levels of access" within the "geographic area served by the organization." MCL 550.53.	BCBSM is to offer coverage throughout the state of Michigan. However, each subscriber's certificate must describe the "service area." MCL 550.1402a. If BCBSM offers a PPO product, it must "assure reasonable levels of access" within the "geographic area served by the organization." MCL 550.53.

VIII. Promulgation of Rules by Commissioner

HMO ACT	Insurance Code	P.A. 350
As a general matter, the Commissioner has authority but is not mandated to promulgate rules.	As a general matter, the Commissioner has authority but is not mandated to promulgate rules.	As a general matter, the Commissioner has authority but is not mandated to promulgate rules.

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IX. Use of Health Status in Premium Rating

HMO ACT	Insurance Code	P.A. 350
Health status is not a permitted rating factor under the HMO Act (MCL 500.3519), nor under Small Group Reform (MCL 500.3705).	No express prohibition and thus may be used as a rating factor. Small Group Reform expressly permits health status as a rating factor. MCL 500.3705.	P.A. 350 does not expressly prohibit health status as a rating factor, however, its use may be viewed as inconsistent with concepts of "equitable" and "uniform" rates under MCL 550.1609 and 550.1611. Health status is not a permitted factor under Small Group Reform. MCL 500.3705. Groups under 100 are currently "community" rated under the Area Rate System filed under MCL 550.1608(2).

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X. Standards for Rates

HMO ACT	Insurance Code	P.A. 350
Fair, sound and reasonable in relation to services provided. MCL 500.3519(1).	As respects certain coverages, supported by actuarial certification that benefits provided are reasonable in relation to the premium charged (must include anticipated loss ratio). MCAR 500.803.	Equitable, adequate (i.e. self sustaining), and not excessive. MCL 550.1608; *See* also MCL 550.1609 regarding what constitutes an excessive, adequate and/or equitable rate. Legislative policy is to have uniform rates. MCL 500.1611.

XI. Small Group Reform Permitted Rating Factors and Rate Variances

HMO ACT	Insurance Code	P.A. 350
Permitted Rating Factors: Industry, Age and Group Size. MCL 500.3705. **Rate Variance:** Variance permitted up to 35% of the index rate. MCL 500.3705(2)(ii).	**Permitted Rating Factors:** Industry, Age, Group Size and Health Status. MCL 500.3705. **Rate Variance:** Variance permitted up to 45% of the index rate. MCL 500.3705(2)(c)(iii).	**Permitted Rating Factors:** Industry and Age. MCL 500.3705. **Rate Variance:** Variance permitted up to 35% of the index rate. MCL 500.3705(2)(ii).

XII. Participation and Provider Contracts

HMO ACT	Insurance Code	P.A. 350
Must arrange services through a provider network subject to access standards. MCL 500.3513(2)(a). May offer a prudent purchaser product (PPO or Point of Service) where enrollees have an out-of-network benefit. MCL 500.3533. Provider contract forms must be filed with OFIR and meet certain requirements. MCL 500.3521; 500.3531.	May offer a prudent purchaser product (PPO or Point of Service) where insureds have a financial incentive to obtain services in-network. MCL 500.3405; 500.3631.	BCBSM must enter into reimbursement arrangements with an "appropriate number" of providers to assure the availability of covered health care services to each subscriber. MCL 550.1504(1). The form of provider contract and the reimbursement arrangement are referred to as "provider class plans." MCL 550.1107. BCBSM is generally prohibited from making payment to non-participating providers. MCL 550.1401(7). BCBSM must make annual filings with respect to class plans relative to statutory goals of cost, quality and access. MCL 550.1504. BCBSM may offer prudent purchaser products (PPO or Point of Service) where the enrollees have a financial incentive to obtain services in-network. MCL 550.1502a. Provider class plan obligations do not apply to PPO or POS products. MCL 550.1502a(10). With respect to professional providers such as physicians, participating contracts may cover all BCBSM members or be a separate contract on per-claim basis. MCL 550.1502(1).

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XIII. Pre-existing Condition Exclusions

HMO ACT	Insurance Code	P.A. 350
A) Individual: Permitted, so long as the exclusion or limitation relates to a condition: a) for which medical advice, diagnosis, care or treatment was recommended or received within 6 months before enrollment; and b) the exclusion or limitation does not extend more than *6 months* after the effective date of the HMO contract. MCL 500.3539(1). **B) Group:** Prohibited. MCL 500.3539(2).	Permitted, so long as the exclusion or limitation relates to a condition: a) for which medical advice, diagnosis, care or treatment was recommended or received within 6 months (individual and group) before enrollment; and b) the exclusion or limitation does not extend more than - 12 months (individual) - 6 months (small group) - 12 months (large group) after the policy takes effect. MCL 500.3406f(a), (b) and (c). Under HIPAA, the exclusion period (group) is required to be reduced by the number of days of "creditable coverage". 45 CFR 146.111.	**Individual:** Permitted, so long as the exclusion or limitation relates to a condition: a) for which medical advice, diagnosis, care or treatment was recommended or received within 6 months before enrollment; and b) the exclusion or limitation does not extend more than *6 months* after the effective date of the certificate. MCL 550.1402b(1). However, BCBSM may not exclude or limit coverage for a pre-existing condition *or impose a waiting period* if a person is deemed to be ***HIPAA eligible.*** MCL 550.1402b(3), 45 CFR 148.128(a)(ii). **Group:** Prohibited. MCL 550.1402b(2).

HMO ACT CROSSWALK

Guaranteed Issue

HMO ACT	Insurance Code	P.A. 350
Individual: HMOs must generally offer coverage during an annual 30-day open enrollment period and may not deny coverage based on health status. MCL 500.3537. HMOs are not subject to HIPAA's guaranteed issue requirements because BCBSM constitutes an "acceptable alternative mechanism" under 45 CFR 148.128. **Small Group:** Must offer all health plans they market to *any* small employer in the state to *all* small employers in the state, and issue a policy to *any* small employer that applies for a plan, agrees to the premium and other reasonable conditions. MCL 500.3707(1). A similar obligation exists under HIPAA. 45 CFR 146.150. HMOs may deny coverage to a small employer group if the group fails to meet the law's minimum participation requirements. MCL 500.3709. **Large Group:** Not required to make coverage available in the large group market.	**Individual:** No requirement to make coverage available in the individual market, so may refuse coverage based on health status. Insurers are not subject to HIPAA's guaranteed issue requirements because BCBSM constitutes an "acceptable alternative mechanism" under 45 CFR 148.128. **Small Group:** Must offer all health plans they market to *any* small employer in the state to *all* small employers in the state and issue a policy to *any* small employer that applies for a plan, agrees to the premium and other reasonable conditions. MCL 500.3707(1). Similar requirement under HIPAA. 45 CFR 146.150. May deny coverage to a small employer group if the group fails to meet the law's minimum participation requirements. MCL 500.3709. **Large Group:** Not required to make coverage available in the large group market.	BCBSM must generally offer coverage to any resident in Michigan. MCL 550.1401(3). While HIPAA contains some additional rules that apply to individual coverage, they do not apply if the state has designated an "alternative mechanism". Michigan has designated BCBSM as the acceptable alternative mechanism. 45 CFR 148.128. Must offer all health plans they market to *any* small employer in the state to *all* small employers in the state and issue a policy to *any* small employer that applies for a plan, agrees to the premium and other reasonable conditions . MCL 500.3707(1). A similar obligation exists under HIPAA. 45 CFR 146.150. May deny coverage to a small employer group if the group fails to meet the law's minimum participation requirements. MCL 500.3709. May deny coverage to non-reform groups under very limited situations where strong evidence of adverse selection. MCL 550.1401.

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Guaranteed Renewal

HMO ACT	Insurance Code	P.A. 350
Individual: Must renew at the option of the individual. MCL 500.3539(3). **Group:** Must renew at the option of the plan sponsor. MCL 500.3539(4). *See also* MCL 500.3711(1) regarding small group (and sole proprietors) guaranteed renewal. A similar guaranteed renewal obligation exists under HIPAA with respect to small and large groups. 45 CFR 146.152.	**Individual:** Must renew at the option of the individual. MCL 500.2213b(1). **Group:** Must renew at the option of the plan sponsor. MCL 500.2213b(2). *See also* MCL 500.3711(1) regarding small group guaranteed renewal. A similar guaranteed renewal obligation exists under HIPAA with respect to small and large groups. 45 CFR 146.152.	**Individual:** Must renew at the option of the individual. MCL 550.1401e(1). **Group:** Must renew at the option of the plan sponsor. MCL 550.1401e(2). A similar guaranteed renewal obligation exists under HIPAA (group). 45 CFR 146.152.

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XIV. Review of Benefit Denials

HMO ACT	Insurance Code	P.A. 350
Must maintain an informal grievance procedure for enrollees to dispute adverse benefit decisions; Also subject to Patient's Right to Independent Review Act ("PRIRA"). MCL 500.2213; MCL 550.1901, et. seq.	Must maintain an informal grievance procedure for enrollees to dispute adverse benefit decisions; Also subject to PRIRA. MCL 500.2213; MCL 550.1901, et. seq.	Must maintain an informal grievance procedure for enrollees to dispute adverse benefit decisions; Also subject to PRIRA. MCL 550.1404; MCL 550.1901, et. seq.